Public Health Capacity Building in Southeastern Europe: A Partnership Between the Open Society Institute and the US Centers for Disease Control and Prevention

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The political disintegration of former Yugoslavia inaugurated in 1991 resulted in the decentralization of health systems in the federation's successor nation-states. Efforts by the Open Society Institute improved public health planning and management needs consequent to health sector changes. Beginning in Croatia in 2001, the Institute developed ongoing collaborations between Andrija Stampar School of Public Health and the US Centers for Disease Control and Prevention. In 2003 and 2004, it expanded its project to include the republics of Macedonia and of Serbia and Montenegro.

KEY WORDS: **Andrija Stampar School of Public Health, Open Society Institute, U.S. Centers for Disease Control and Prevention, health policy development, health planning, public health, Croatia, Macedonia, former Yugoslavia**

Introduction

Ethnic wars in the 1990s resulted in the disintegration of federal Yugoslavia. Five constituent republics emerged: Bosnia-Herzegovina, Croatia, Macedonia, Serbia and Montenegro, and Slovenia. These independent countries underwent successively profound political, social, and economic transformations. Three factors drove these transformations[1,2]:

- Their established independence
- Recurring ethnic conflicts
- Often precipitous, politically motivated governance-systems reforms

One of the major impacts was that public health systems had greatly deteriorated, failing to respond to altered circumstances.[3] S. Sogoric, DrSc, et al. (unpublished data, 2003) have outlined this situation in their report.

In recent years, multinational institutions have driven and implemented health sector reform in most former Yugoslav republics, including the European Union, the World Bank, and the International Monetary

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Fund. Decentralization and health sector reform has resulted in county-level authorities' assuming public health planning and management responsibilities that require intensive training.

The refugee crisis that followed the Yugoslav wars in the 1990s attracted worldwide attention, and humanitarian aid poured in from international governmental and nongovernmental organizations (NGOs). One such NGO was the Open Society Institute (OSI), founded by financier George Soros to administer and coordinate his philanthropic activities.

Beginning in 2001, the OSI sponsored a partnership for training between government institutions in Croatia and Macedonia and the US Centers for Disease Control and Prevention (CDC) in Atlanta. This partnership addressed pressing county-level capacity needs consequent to health services decentralization.

Open Society Institute Public Health Initiatives

The OSI has supported innovation and program development in a range of areas, including public health. The philanthropy has applied an approach that focuses on identifying important yet neglected health needs. Significantly, the foundation also often works closely with local stakeholders to strategize and formulate interventions that address these deficiencies. The developers usually begin these interventions with an evaluative pilot, reflecting the core public health functions: assessment, policy development, delivery assurance.

The OSI's first engagement with public health in Eastern Europe began in 1995 with the launching of the International Harm Reduction Development (IHRD) program. This initiative diminished the individual and social harms associated with drug abuse, particularly HIV infection risk. By 2003, the IHRD had supported nearly 200 community-based harm reduction projects in 28 countries in Eastern Europe and the former Soviet Union. The IHRD raised global awareness of the interrelation between drug abuse and HIV epidemics, as well as specific issues facing vulnerable groups such as injecting drug users. Repressive drug policies in some countries continue to obstruct comprehensive public health efforts in HIV prevention and treatment. Despite these obstacles, the OSI's strategy yielded remarkable, successful outcomes that promoted positive changes in how societies treat their drug users.[4,5]

The OSI progressed in its global or regional advocacy efforts in other public health areas, such as tuberculosis control and mental health. Limited management capacity and stakeholder investment often hampered program implementation. In Croatia and Macedonia, the OSI's approach has been to address specific management and stakeholder challenges related to health sector decentralization.

Health Sector Changes in Yugoslavia

> Decentralization is not an end in itself but rather should be designed and evaluated for its ability to achieve broader objectives of health reform: equity, efficiency, quality and financial soundness.[6]

> Decentralization is commonly politically driven. This can lead to many avoidable mistakes if planners are not given an opportunity to provide necessary input or if they lack sufficient information to understand the decentralization process. Planning *for* decentralization should be based on a clear understanding of the motivating and opposing forces for decentralization, as well as its explicit and implicit objectives.[7]

Health care systems of Yugoslavia and its successor republics underwent several transformations since World War II. Changes generally reflected political developments, echoing cyclical swings between centralized or decentralized governance approaches.

The first postwar shift occurred in 1945, when Yugoslavia aligned with the Soviet Union for a short time. A centralized state administration of the health sector modelled on the Soviet Semaskho health system resulted. Yugoslavia's political break with the Soviet Union in 1948 led by 1952 to the rejection of centralized health administration. During the 1950s and 1960s, the country developed an increasingly decentralized institutional framework to foster democracy, equity, and efficiency through self-management and local financing.

As with similar frameworks, this initiative did not always achieve the desired outcomes. For example, new councils introduced in 1960 were intended to give community representatives greater decision-making responsibilities. However, this effort tended to overrepresent male experts and underrepresent female workers and civil society stakeholders.

Meanwhile, the federal-level ideological commitment to self-managing socialism and the "withering away of the state" did not preclude ad hoc state interventions driven by a range of motives. County, republic, and federal politicians, bureaucrats, and experts mandated health services in response to special interests or political considerations. These mandates did not necessarily address ascertained needs and, indeed, contradicted the professed goal of self-managing socialism.[8(pp724,727)] This intermittent, supply-driven practice weakened the intended community-oriented policy-making process. Moreover, it eroded local health management effectiveness.[8(p722)] Efficiency and equity of the health sector gradually declined. This deterioration diminished universal health coverage achievements and failed to stem the impact of waning socioeconomic indicators.[9,10]

One perhaps overly critical observer commented that the health system inherited by successor states from Yugoslavia was "a unique blend of health insurance funds, a network (although neglected) of primary healthcare, quasi-autonomous health organizations and community management. The result was an extremely liberal system, verging on anarchy, which satisfied nobody."[11] In 1985, another investigator wrote, "some form of continuous and legitimate central coordination may be necessary to resolve current critical problems in Yugoslav healthcare."[8(p719)]

This imperfect system's troubles compounded during the 1990s independence movements and wars. At the time, the newly independent nations began organizing their health systems. The historically decentralized system had become associated with discredited Yugoslav policies. Therefore, the new policy makers made it a vulnerable target. For example, the Croatian Ministry of Health, driven by the added factor of war mobilization, legislated health service centralization. (S. Sogoric et al, unpublished data, 2003) Another development was the privatization of primary healthcare to decrease costs and increase efficiency.[12] Macedonia experienced a similar process.[13,14]

In the early 1990s, therefore, Croatia and Macedonia recentralized their health services. Ironically, during this same time period, most Eastern European states abandoned socialist-era central planning, including in health services. In part, a similar impetus drove them: the rejection of the former regime and policies.[15,16] More recently, Croatia and Macedonia have reversed their policies, moving toward decentralized health systems, largely because transnational financial and development institutions mandated such a shift.

Political developments frequently drive health system reforms. Such shifts, depending on circumstances, may detract from the sound health policy objectives of equity, efficiency, and quality. Critics point out that governments often implement decentralization "with surprisingly little thought for how it would work in practice."[15]

The OSI project described in this article was not a driving factor of the decentralization process in Croatia and Macedonia. However, the project succeeded in addressing a far-reaching decentralization consequence: an urgent need for local management and policy capacity.

Improving Public Health Management and Policy-Making Capacity

Croatia

By the end of the 1990s, most Croatian public health faculty and professionals concurred that health services responded insufficiently to population needs. Furthermore, centralizing tendencies in place since 1991 undermined health system capacity to meet those needs. The Motovun Summer School of Health Promotion, an affiliate of the Andrija Stampar School of Public Health (ASSPH) in Zagreb, hosted in 1999 a gathering of 25 public health experts to analyze the situation. The workshop applied a CDC assessment tool, the Local Public Health Practice Performance Measures Instrument. Participants identified a series of county-level deficiencies prevalent in public health practice and policy:

- Priority setting in the public health policy formulation process.
- Strategy development and planning to address identified priorities.
- Community participation and stakeholder input in the policy development process.
- Public health policy assurance and evaluation.
- Analytical approaches to the adequacy of health resource allocation.

The Motovun meeting's conclusions might have passed unnoticed if unveiled at a less propitious time. However, the newly elected national government had committed to reforming the public sector, with decentralization defined as a major priority. National policy makers therefore received some of these articulated ideas positively, particularly those calling for greater community participation, increased responsibility, and expanded decision-making power for county council health and social welfare authorities (S. Sogoric et al, unpublished data, 2003).

In 2001, the OSI invited ASSPH to train at the CDC's Sustainable Management Development Program (SMDP) and to participate in a multiyear initiative addressing the need for improved management skills of Croatian public health workers. Established in 1992, the SMDP develops local training capacity to improve management of public health programs internationally.

Trainers from around the world attend SMDP's six-week course Management for International Public Health, based in Atlanta, to develop their management training competencies. The SMDP staff later provide in-country technical assistance to course graduates as they develop and teach applied workshops for local program managers. Overall, the SMDP emphasizes creating local stakeholder capacity to establish their own priorities and develop strategies and policies to address them.[17]

The CDC and OSI also recognized that they shared an interest in offering SMDP training and technical assistance to Central and Eastern European countries, where decentralization demands trained public health managers. Croatia was selected as the pilot country

because it met several conditions critical to the study:

- The existence of a strong Croatian training team at ASSPH able to perpetuate and divulge local and regional capacity.
- A well-defined policy need based on the Motovun assessments.
- The presence of committed stakeholders at local (county) and national levels.
- A high probability of policy impact due to early involvement of key stakeholders.

As a start, two senior faculty members of the ASSPH underwent training through SMDP's September 2001 course Management for International Public Health. Returning to Croatia, they developed a unique training program entitled Healthy Counties. Its goal was to help counties assess population health needs in a participative manner, to select health priorities, to develop health plans and, ultimately, ensure provision of quality services tailored to population health needs. The program was focused on cross-sectoral collaboration, a participative or "bottom-up" approach, and the use of qualitative analysis. The curriculum was developed according to recognized management tools, public health theory and practice, and the use of SMDP's Healthy Plan-*it*™. Faculty members designed it in collaboration with a number of panels composed of public health professionals from county and national institutes of public health; the Croatian ministries of health, labor, and social welfare; and other county officials.

The program set out to train county teams in public health priority setting, planning, policy development, and assurance. Each county team included three representatives of civil society (associations, nongovernmental organizations, media), three from executive and political stakeholders, and three from technical components (county-level institutes of public health and social welfare centers). The planned outputs were County Health Profiles and County Health Plans outlining priorities and implementation strategies.

By August 2004, 16 county teams had undergone the training programs and produced county health plans with prioritized health needs and specific recommendations for addressing them. The strategic health plans were accepted and approved by a majority of county councils. Several plans outlined action plans and ensured adequate financing for project implementation in priority areas such as

- Female breast cancer
- Enhancement of social care for the elderly and people with special needs
- Cardiovascular diseases
- Promotion of mental health
- Prevention of drug and alcohol abuse by young people.

While too early to evaluate long-term outcomes and impact on population health, the training process revealed priorities of local and national relevance. Thus, this set the stage for a national policy-making process concerted and relevant to local needs. The program also successfully stimulated a cross-sectoral, county-level collaboration that included community participation.[18]

Currently, ASSPH's management training focuses on a trainee subset from the *Healthy Counties* project. The trainees consist of *troikas*, groups of three people in county leadership positions: one elected official; one professional civil servant from the county administration; and one professional from the county public health institute. In the course of 2004, the *troikas* were trained in the following topics:

- Comprehensive care for the elderly
- Female breast carcinoma
- Total Quality Management.

To develop the Total Quality Management training plan, two additional ASSPH faculty members attended the 2003 MIPH course. The curriculum emphasized problem-solving and process-improvement skills to enhance the quality of health and social welfare services, particularly in hospitals.

Macedonia

The OSI's early success with Croatia's Healthy Counties project stimulated interest in replicating the process in Macedonia. Therefore, in 2002, the OSI initiated collaborations with SMDP, ASSPH, the Macedonian Ministry of Health, and the Medical School Chair for Social Medicine of St Cyril and Methodius University in Skopje, Macedonia. In August 2002 in Washington, DC, the program held its inaugural meeting, where representatives from Croatia, Macedonia, SMDP, and OSI established parameters for the project.

From January to May 2003, three Macedonians participated in a complete Healthy Counties training cycle of four workshops in Croatia. In that year, they developed a formal agreement. Subsequently, OSI, the School of Medicine, and the Ministry of Health signed an agreement to develop and implement the planned management-capacity–building project.

In June 2003, the OSI and the School of Medicine organized a one-day conference in Ohrid. They introduced the project draft plan to high-level Ministry of Health representatives, the media, elected officials, and health professionals from the 10 Macedonian city regions, administrative equivalents to Croatia's county structures. The ASSPH faculty, representatives from

three counties, and the SMDP staff presented background, description, and experiences from Croatia's Healthy Counties project. Sixty people attended, including Macedonia's health minister, OSI's country director, the School of Medicine's dean, representatives of Macedonian nongovernmental organizations supported by OSI, delegates from the national and local institutes of public health, mayors, and journalists.

The ASSPH's Healthy Counties training team conducted a follow-up workshop at the same location. They exposed 31 attendees to management concepts for future training activities. Participant evaluations indicated strong interest and enthusiasm for training and capacity development.

In fall 2003, the first 2 faculty members from the School of Medicine's Department of Social Medicine attended the SMDP course in Atlanta and produced a training plan modeled on Croatia's Healthy Counties. However, they incorporated a number of changes reflecting Macedonia's specific situation and training needs. Titled the Health Management and Governance project, its implementation has been in progress since 2003.

The Department of Social Medicine of the Medical School of St Cyril and Methodius University is responsible for developing and implementing the training activities. Meanwhile, the OSI supports SMDP technical assistance and train-the-trainers costs for six Macedonian faculty. Macedonian governmental authorities fund local training and implementation costs.

The program will implement training over three years in the 10 regional Institutes for Public Health and teach four modules: assessment functions, priority setting, policy development, and assurance. Project developers will present to national authorities the planned outcomes, city-region health profiles, and action plans. Following a pattern established by the Croatian project, the initiative has scheduled a Total Quality Management training for hospital managers in late 2004 and in 2005.

Conclusions

The Healthy Counties project in Croatia and its counterpart in Macedonia illustrate the positive influence of a health-oriented philanthropy. The approach supports system improvement that fosters local-level participative decision making and sound governance.

This model has built local planning capacity and enacted county-level health plans in Croatia. This successful, exemplary collaboration involves

- Andrija Stampar School of Public Health, a regionally strong school of public health with a long history
- Local public health officials and stakeholders
- The CDC, an internationally respected health agency.
- The OSI, an international nongovernmental philanthropic organization

Moreover, county governments and the Ministry of Health have shared all project training and implementation costs, with strong prospects for sustainability.

The Croatian plan spurred a similar implementation initiative in Macedonia. The ASSPH has exerted leadership and abetted a similar role for the Department of Social Medicine of the Medical School. Serbia and Montenegro plan to launch a similar capacity-building program in Fall 2004.

Significantly, Croatia's Healthy Counties and Macedonia's Health Management and Governance projects may also be relevant to policy makers outside southeastern Europe, especially given the broader context of public health services decentralization, a far-reaching global trend. Decentralization critics often report that little is being done to prepare local authorities adequately for their new responsibilities to assess, develop, manage, and fund community-level public health services. Applied training programs such as the CDC's MIPH course teach policy and management skills instrumental in building local and national capacity, thus filling the gap that often develops between policies and their successful implementation. Copious literature debating the merits of decentralization exists.[18–29] A small sampling of this literature contains both favorable and negative critiques of decentralization or explores aspects not discussed in this article. Overall, a general consensus exists supporting the need for local capacity training in management and leadership skills.

The prototypal project described above merits further study, particularly outcome evaluation. However, progress to date indicates that capacity developed at the local level must accompany decentralization. Countries and governments can best accomplish this goal through partnerships involving local stakeholders, training institutions such as public health schools and institutes, and governmental organizations. International organizations, such as the OSI and CDC, can play an instrumental brokering, training, and technical assistance role. International aid for development should recognize the existence of a hierarchy of capacity-building needs and of complex sociocultural realities on the ground.[30,31] Finally, national and local stakeholders must develop and execute the policies and their implementation according to core public health functions: assessment, policy development, and delivery assurance.

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